

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-005302

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. **042** Primary Registration District No. **1000** Registrar's No. **164**  
**FILED FEB 18 1963**

STATE FILE NUMBER

VS 300  
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS  
INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF  
DE. Sklenar, M.D.

|  |   |  |   |
|--|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY <b>Buchanan</b>   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)<br>a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>                          |   |
| b. CITY (If outside corporate limits, give TOWNSHIP only)<br><b>St. Joseph</b>   |   | c. CITY OR TOWN <b>St. Joseph</b>  | Inside Limits<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>  |
| c. FULL NAME OF (If NOT in hospital, give location)<br><b>813 Parker</b>   |   | d. STREET ADDRESS (If outside, give location)<br><b>324 No 10 St.</b>  | Reside on Farm<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED<br>(Type or print) <b>MINNIE ALMIRA CUSTER</b>   |   | 4. DATE OF DEATH<br>Month <b>February</b> Day <b>8</b> Year <b>1963</b>  |   |
| 5. SEX<br><b>Female</b>  | 6. COLOR OR RACE<br><b>white</b>  | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/><br>Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>          | 8. DATE OF BIRTH<br><b>10/30/1878</b>   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>                                |   | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>   | 9. AGE (last birthday)<br><b>84</b>   |
| 11. BIRTHPLACE (City and state or country)<br><b>Indiana</b>   |   | 12. CITIZEN OF WHAT COUNTRY<br><b>U S A</b>  |   |
| 13a. FATHER'S NAME<br><b>Martin Boose</b>  |   | 13b. MOTHER'S MAIDEN NAME<br><b>Sarah Collins</b>  |   |
| 14. NAME OF HUSBAND OR WIFE<br><b>Deceased</b>   |   | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no, or unknown) <b>no</b>   |   |
| 16. SOCIAL SECURITY NO.<br><b>[REDACTED]</b>   |   | 17. INFORMANT<br><b>George Penland</b> Address <b>St. Joseph, Mo</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>           |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b>   |   |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last:<br>DUE TO (b) <b>Arteriosclerotic Heart Disease</b> |   | Unknown  |   |
| DUE TO (c)   |   |  |   |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)              |   | PART III. If deceased was female was there a pregnancy in last 90 days.<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |   |
| 19. WAS AUTOPSY PERFORMED?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)   |   |
| 20c. TIME OF INJURY<br>Hour <b>[REDACTED]</b> Month, Day, Year <b>[REDACTED]</b>   | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>    |  |   |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   | 20f. CITY, TOWN, OR LOCATION<br><b>St. Joseph, Mo</b>   |  |   |
| 21. I attended the deceased from <b>1/2/63</b> to <b>2/8/63</b> and last saw her alive on <b>2/4/63</b>  |   | Death occurred at <b>8:15 P.m.</b> on the date stated above, and to the best of my knowledge, from the causes stated.  |   |
| 22a. SIGNATURE<br><b>W. E. Sklenar M.D.</b>  |   | 22b. ADDRESS<br><b>Social Welfare Board 10th &amp; Olive, St. Joseph, Mo.</b>  |   |
| 22c. DATE SIGNED<br><b>2/11/63</b>   |   | 23a. BURIAL, CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |   |
| 23b. DATE<br><b>2/12/63</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Glenwood Cemetery</b>  | 23d. LOCATION (City, town, or county)<br><b>Glenwood Iowa</b>  |   |
| 24. FUNERAL DIRECTOR<br><b>[REDACTED]</b>  |   | 25. DATE RECD. BY LOCAL REG.<br><b>Feb. 14, 1963</b>   |   |
| 26. REGISTRAR'S SIGNATURE<br><b>[REDACTED]</b>   |   |  |   |

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

Permit issued 2/11/63

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Charles E. Bennett*

Licensed Embalmer No. 4677

P. O. Address St Joseph Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.